

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008543

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2283

FILED MAR 7 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Length of stay in 1b

56 YRS.

a. STATE

b. COUNTY

c. CITY OR TOWN

ST. LOUIS

d. STREET ADDRESS

3510 HARPER ST.

Inside Limits

Yes ☒ No ☐

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

WALTER

Middle

R. O'LOUGHLIN

Last

4. DATE OF DEATH

Month

2

Day

24

Year

1962

5. SEX

M

6. COLOR OR RACE

W

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH

4-20-1905

9. AGE (last birthday)

56

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHAUFFEUR

10b. KIND OF BUSINESS OR INDUSTRY

TRUCKING CO.

11. BIRTHPLACE (City and state or country)

ST. LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

JOHN O'LOUGHLIN

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

MARIE O'LOUGHLIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or (unknown)) (If yes, give war or dates of service)

NO

17. INFORMANT

MRS. SHARON M. O'NEAL 4115 W. CARTER

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Jan 11-62 to Feb 24-62 and last saw him alive on Feb 19-62. Death occurred at 1:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

MD

22b. ADDRESS

3700 N Grand St

22c. DATE SIGNED

2/26/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

2-27-1962

23c. NAME OF CEMETERY OR CREMATORY

CALVARY CEM.

23d. LOCATION (City, town, or county)

ST. LOUIS, MO.

24. FUNERAL DIRECTOR

ADDRESS

SUEDMEYER & SONS 3934 N 20TH ST

25. DATE REC'D. BY LOCAL REG.

FEB 26 1962

26. REGISTRAR'S SIGNATURE

Loal Smith, M.D.

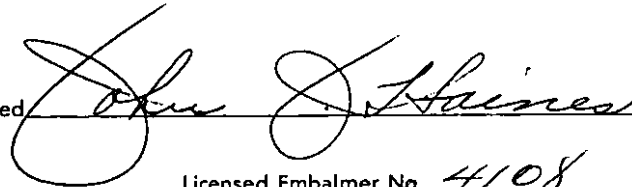
USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4108

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.